

STATE OF ILLINOIS

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Facility Name & ID Number Heritage Manor-Springfield# 0041699 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds 9/10/03

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>176</u>	Skilled (SNF)	<u>178</u>	<u>65,194</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>0</u>	Intermediate (ICF)	<u>0</u>	<u>0</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>176</u>	TOTALS	<u>178</u>	<u>65,194</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>32,100</u>	<u>16,261</u>	<u>9,646</u>	<u>58,007</u>	8
9	SNF/PED			<u>0</u>		9
10	ICF					10
11	ICF/DD					11
12	SC	<u>0</u>	<u>0</u>	<u>0</u>		12
13	DD 16 OR LESS					13
14	TOTALS	<u>32,100</u>	<u>16,261</u>	<u>9,646</u>	<u>58,007</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 88.98%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 1996

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified _____ and days of care provided 9,646

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

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Facility Name & ID Number Heritage Manor-Springfield

0041699

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	342,843	21,588		364,431		364,431	4,594	369,025		1
2	Food Purchase		205,032		205,032		205,032		205,032		2
3	Housekeeping	165,307	36,587		201,894		201,894		201,894		3
4	Laundry	105,695	28,936		134,631		134,631		134,631		4
5	Heat and Other Utilities			163,441	163,441		163,441	2,038	165,479		5
6	Maintenance	165,620	65,068	40,907	271,595		271,595	20,448	292,043		6
7	Other (specify):*										7
8	TOTAL General Services	779,465	357,211	204,348	1,341,024		1,341,024	27,080	1,368,104		8
	B. Health Care and Programs										
9	Medical Director			17,600	17,600		17,600		17,600		9
10	Nursing and Medical Records	2,780,402	211,335	10,339	3,002,076		3,002,076		3,002,076		10
10a	Therapy		624,715	541,810	1,166,525	(815,470)	351,055	346,797	697,852		10a
11	Activities	101,123	5,672		106,795		106,795		106,795		11
12	Social Services	97,307		825	98,132		98,132		98,132		12
13	Nurse Aide Training		50		50		50	3,160	3,210		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,978,832	841,772	570,574	4,391,178	(815,470)	3,575,708	349,957	3,925,665		16
	C. General Administration										
17	Administrative	77,731			77,731		77,731	126,710	204,441		17
18	Directors Fees							11,492	11,492		18
19	Professional Services			369,872	369,872		369,872	(342,015)	27,857		19
20	Dues, Fees, Subscriptions & Promotions			122,059	122,059	(97,791)	24,268	(2,834)	21,434		20
21	Clerical & General Office Expenses	280,261	28,187	33,422	341,870		341,870	358,739	700,609		21
22	Employee Benefits & Payroll Taxes			744,549	744,549		744,549	51,448	795,997		22
23	Inservice Training & Education			746	746		746	1,392	2,138		23
24	Travel and Seminar			5,533	5,533		5,533	(3,534)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			97,779	97,779		97,779	3,546	101,325		26
27	Other (specify):*			5,223	5,223		5,223	(5,136)	87		27
28	TOTAL General Administration	357,992	28,187	1,379,183	1,765,362	(97,791)	1,667,571	199,808	1,867,379		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,116,289	1,227,170	2,154,105	7,497,564	(913,261)	6,584,303	576,845	7,161,148		29

* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name & ID Number Heritage Manor-Springfield

#0041699

Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			297,113	297,113		297,113	17,676	314,789			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			109,159	109,159		109,159	13,581	122,740			32
33	Real Estate Taxes			111,275	111,275		111,275		111,275			33
34	Rent-Facility & Grounds							11,812	11,812			34
35	Rent-Equipment & Vehicles			910	910		910	18,217	19,127			35
36	Other (specify):*											36
37	TOTAL Ownership			518,457	518,457		518,457	61,286	579,743			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					815,470	815,470		815,470			39
40	Barber and Beauty Shops			16,675	16,675		16,675		16,675			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					97,791	97,791		97,791			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			16,675	16,675	913,261	929,936		929,936			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,116,289	1,227,170	2,689,237	8,032,696		8,032,696	638,131	8,670,827			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number **Heritage Manor-Springfield**# **0041699**

Report Period Beginning:

01/01/2003

Ending:

12/31/2003**VI. ADJUSTMENT DETAIL****A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	478	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(2,044)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(845)	20		17
18	Fines and Penalties				18
19	Entertainment	(13,536)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,793)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,136)	27		24
25	Fund Raising, Advertising and Promotional	(8,136)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (36,012)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	674,143		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 674,143		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 638,131		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Heritage Manor-Springfield

ID# 0041699

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$		1
2			2
3			3
4			4
5		478	35
6		0	34
7			7
8			8
9		0	30
10			32
11			11
12			12
13		0	2
14			32
15		0	33
16			24
17		(845)	20
18			18
19			24
20		0	27
21			21
22		(6,793)	19
23			23
24		(5,136)	27
25		(8,136)	20
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(20,432)	49

Summary A

12/31/2003

(to Sch V, col.7)

[illegible]

Summary B

Facility Name & ID Number	Heritage Manor-Springfield	#	0041699	Report Period Beginning:	01/01/2003	Ending:	12/31/2003
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	TOTALS
												(to Sch V, col.7)
30	Depreciation	0	0	0	17,676	0	0	0	0	0	0	17,676
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0
32	Interest	(2,044)	0	0	15,625	0	0	0	0	0	0	13,581
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0
34	Rent-Facility & Grounds	0	0	0	11,812	0	0	0	0	0	0	11,812
35	Rent-Equipment & Vehicles	478	0	0	17,739	0	0	0	0	0	0	18,217
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0
37	TOTAL Ownership	(1,566)	0	0	62,852	0	0	0	0	0	0	61,286
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(36,012)	(7,782)	619,073	62,852	0	0	0	0	0	0	638,131

Facility Name & ID Number Heritage Manor-Springfield# 0041699

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$	\$	1
2	V	10a Adjustment for Related Organization	508,066	GreenTree Therapy	100.00%	693,973	185,907	2
3	V							3
4	V	19 Adjustment for Related Organization	354,579	Heritage Enterprises, Inc.	100.00%		(354,579)	4
5	V							5
6	V	10a Adjustment for Related Organization	618,877	GreenTree Pharmacy	100.00%	779,767	160,890	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,481,522			\$ 1,473,740	\$ * (7,782)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Springfield# 0041699Report Period Beginning: 01/01/2003Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	100.00%	\$ 4,594	\$ 4,594
16	V	2 Food Purchase				0	
17	V	3 Housekeeping				0	
18	V	4 Laundry				0	
19	V	5 Heat & Other Utilities				2,038	2,038
20	V	6 Maintenance				20,448	20,448
21	V	7 Other				0	
22	V	9 Medical Director				0	
23	V	10 Nursing & Medical Records				0	
24	V	11 Activities				0	
25	V	12 Social Service				0	
26	V	13 Nurse Aide Training				3,160	3,160
27	V	14 Program Transportation				0	
28	V	15 Other				0	
29	V	17 Administrative				126,710	126,710
30	V	18 Directors Fees				11,492	11,492
31	V	19 Professional Services				19,357	19,357
32	V	20 Fees, Subscription, Promotions				6,147	6,147
33	V	21 Clerical & General Office Expenses				358,739	358,739
34	V	22 Employee Benefits & Payroll Taxes				51,448	51,448
35	V	23 Inservice Training & Education				1,392	1,392
36	V	24 Travel and Seminar				10,002	10,002
37	V	25 Other Admin. Staff Transportation				0	
38	V	26 Insurance-Prop.Liab.Malpract				3,546	3,546
39	Total		\$			\$ 619,073	\$ * 619,073

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Springfield# 0041699Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	27 Other	\$	Heritage Enterprises, Inc.	100.00%	\$ 0	\$
16	V	30 Depreciation				17,676	17,676
17	V	31 Amortization of Pre-Op & Org				0	
18	V	32 Interest				15,625	15,625
19	V	33 Real Estate Taxes				0	
20	V	34 Rent-Facility & Grounds				11,812	11,812
21	V	35 Rent-Equipment & Vehicles				17,739	17,739
22	V	36 Other				0	
23	V	38 Medically Nec Transportation				0	
24	V	39 Ancillary Service Centers				0	
25	V	40 Barber and Beauty Shops				0	
26	V	41 Coffee and Gift Shops				0	
27	V	42 Other				0	
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 62,852	\$ * 62,852

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bill Froelich	Director	Management	26.00	320,135	5	100.00	Director/Salary	\$ 23,715	line 17/18, col	1
2	Tom Jefferson	Secretary	Management	10.00	385,686	5	100.00	Director/Salary	28,569	line 17/18, col	2
3	Craig Hart	Chairman	Management	20.00	372,740	10	100.00	Director/Salary	27,610	line 17/18, col	3
4	Cheryl Lowney	Executive Vice Presi	Management	0.30	222,499	40	100.00	Director/Salary	16,481	line 17/18, col	4
5	Steve Wannemacher	President	Management	0.30	251,231	40	100.00	Director/Salary	18,610	line 17/18, col	5
6	Connie Hoselton	Sr Vice President	Management	0.20	148,865	40	100.00	Salary	11,027	line 17, col 7	6
7	Craig Ater	Sr Vice President	Management	0.20	164,565	40	100.00	Salary	12,190	line 17, col 7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 138,202		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heritage Manor-Springfield# 0041699

Report Period Beginning:

01/01/2003Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1 Dietary	Beds	2,403	24	\$ 62,023	\$ 62,023	178	\$ 4,594	1
2	2 Food Purchase	Beds	2,403	24	0	0	178	0	2
3	3 Housekeeping	Beds	2,403	24	0	0	178	0	3
4	4 Laundry	Beds	2,403	24	0	0	178	0	4
5	5 Heat & Other Utilities	Beds	2,403	24	27,509	0	178	2,038	5
6	6 Maintenance	Beds	2,403	24	276,052	67,064	178	20,448	6
7	7 Other	Beds	2,403	24	0	0	178	0	7
8	9 Medical Director	Beds	2,403	24	0	0	178	0	8
9	10 Nursing & Medical Records	Beds	2,403	24	0	0	178	0	9
10	11 Activities	Beds	2,403	24	0	0	178	0	10
11	12 Social Service	Beds	2,403	24	0	0	178	0	11
12	13 Nurse Aide Training	Beds	2,403	24	42,658	42,572	178	3,160	12
13	14 Program Transportation	Beds	2,403	24	0	0	178	0	13
14	15 Other	Beds	2,403	24	0	0	178	0	14
15	17 Administrative	Beds	2,403	24	1,710,580	0	178	126,710	15
16	18 Directors Fees	Beds	2,403	24	155,144	0	178	11,492	16
17	19 Professional Services	Beds	2,403	24	261,316	0	178	19,357	17
18	20 Fees, Subscription, Promotions	Beds	2,403	24	82,980	0	178	6,147	18
19	21 Clerical & General Office Expense	Beds	2,403	24	4,842,980	4,501,882	178	358,739	19
20	22 Employee Benefits & Payroll Tax	Beds	2,403	24	694,554	0	178	51,448	20
21	23 Inservice Training & Education	Beds	2,403	24	18,789	0	178	1,392	21
22	24 Travel and Seminar	Beds	2,403	24	135,033	0	178	10,002	22
23	25 Other Admin. Staff Transportation	Beds	2,403	24	0	0	178	0	23
24	26 Insurance-Prop.Liab.Malpract	Beds	2,403	24	47,877	0	178	3,546	24
25	TOTALS				\$ 8,357,495	\$ 4,673,541		\$ 619,073	25

Facility Name & ID Number Heritage Manor-Springfield# 0041699

Report Period Beginning:

01/01/2003Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27 Other	Beds	2,403	24	\$	\$	178	\$	1
2	30 Depreciation	Beds	2,403	24	238,628		178	17,676	2
3	31 Amortization of Pre-Op & Org	Beds	2,403	24			178		3
4	32 Interest	Beds	2,403	24	210,931		178	15,625	4
5	33 Real Estate Taxes	Beds	2,403	24			178		5
6	34 Rent-Facility & Grounds	Beds	2,403	24	159,466		178	11,812	6
7	35 Rent-Equipment & Vehicles	Beds	2,403	24	239,478		178	17,739	7
8	36 Other	Beds	2,403	24			178		8
9	38 Medically Nec Transportation	Beds	2,403	24			178		9
10	39 Ancillary Service Centers	Beds	2,403	24			178		10
11	40 Barber and Beauty Shops	Beds	2,403	24			178		11
12	41 Coffee and Gift Shops	Beds	2,403	24			178		12
13	42 Other	Beds	2,403	24			178		13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 848,503	\$		\$ 62,852	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Bank of Springfield		xx	Mortgage	\$17,720.00	05/01/02	\$ 2,800,000	\$ 2,640,888	05/1/07	variable	\$ 108,644	1	
2	Bank of Springfield		xx	Mortgage -- Loan fees							515	2	
3												3	
4												4	
5												5	
	Working Capital												
6	Bank of Springfield		xx	Working Capital				200,000				6	
7	Central Office Allocation		xx	Working Capital							15,625	7	
8												8	
9	TOTAL Facility Related				\$17,720.00		\$ 2,800,000	\$ 2,840,888			\$ 124,784	9	
	B. Non-Facility Related*												
10	Interest Income										(2,044)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (2,044)	14	
15	TOTALS (line 9+line14)						\$ 2,800,000	\$ 2,840,888			\$ 122,740	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor-Springfield COUNTY SANGAMON

FACILITY IDPH LICENSE NUMBER 0041699

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>14280277027</u>	<u>Heritage Manor-Springfield</u>	\$ <u>109,245.00</u>	\$ <u>109,245.00</u>
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>109,245.00</u>	\$ <u>109,245.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
B. General Construction Type:
Exterior
Frame
Number of Stories

C. Does the Operating Entity?
(a) Own the Facility
(b) Rent from a Related Organization.
(c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity?
(a) Own the Equipment
(b) Rent equipment from a Related Organization.
(c) Rent equipment from Completely Unrelated Organization.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
YES
NO

If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Land			\$ 630,000	1
2					2
3	TOTALS			\$ 630,000	3

Facility Name & ID Number Heritage Manor-Springfield

0041699

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Accumulated Depreciation
4	178	1963		\$ 1,870,000	\$		\$	\$
5		1966		1,648,258				
6		1999						
7								
8								
Improvement Type**								
9	1985 Improvements	1985		26,076				
10	1986 Improvements	1986		216,545				
11	1987 Improvements	1987		593,121				
12	1988 Improvements	1988		29,321				
13	1989 Improvements	1989		1,095				
14	1990 Improvements	1990		939				
15	1991 Improvements	1991		32,022				
16	1992 Improvements	1992		32,593				
17	1993 Improvements	1993		105,986				
18	1994 Improvements	1994		59,542				
19	1995 Improvements	1995		36,126				
20	Laundry Chute	1996		4,926				
21	Door Alarm	1996		8,533				
22	Garbage Disposal	1996		1,113				
23	Elevator	1996		11,439				
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34	C/O Allocation						17,676	
35	Book Depreciation				210,975		210,975	1,893,164
36								

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	2 Year Constructed	3 Cost	4 Current Book Depreciation	5 Life in Years	6 Straight Line Depreciation	7 Adjustments	8 Accumulated Depreciation	9
37	Vent Shaft	1997	\$ 6,267	\$		\$	\$	\$	37
38	Fire Dampers	1997	510						38
39	Computer Cabling	1997	14,518						39
40	Rehab Therapy Room	1997	7,391						40
41	Air Conditioner--Chiller	1997	47,954						41
42	Remodel First Floor	1997	27,570						42
43									43
44	Landscape	1998	2,410						44
45	Vent Work	1998	7,018						45
46	Asphalt Ramp	1998	850						46
47	Room Remodel	1998	1,142						47
48									48
49	Code Alert	1999	7,829						49
50	Wall Paper	1999	704						50
51	Remodel Office Interior	1999	1,248						51
52	Elevator Repair	1999	2,697						52
53	Carpet	1999	1,097						53
54									54
55	Shed Yardmate	2000	522						55
56	A/C Rooftop Unit	2000	2,937						56
57	Sewerline Repair	2000	1,482						57
58									58
59	Facility Renovation--Materials	2001	745,911						59
60	Facility Renovation--Labor	2001	1,463						60
61	Facility Renovation--Interior Design	2001	69,313						61
62	Fire Alarm System	2001	8,718						62
63	Sewer Line Repair	2001	1,787						63
64									64
65	Facility renovations: Paint , wallpaper, fixtures , floor coverings for all resident								65
66	rooms including hallways and common areas								66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,638,973	\$ 210,975		\$ 228,651	\$ 17,676	\$ 1,893,164	70

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,638,973	\$ 210,975		\$ 228,651	\$ 17,676	\$ 1,893,164	1
2	Landscape Design	2002	500						2
3	Freezer Compressor	2002	3,834						3
4	Smoke Detectors	2002	2,560						4
5	Facility Renovation--Materials	2002	186,172						5
6	Facility Renovation--Labor	2002	3,561						6
7	Facility Renovation--Interior Design	2002	15,497						7
8	Phone System	2002	2,064						8
9									9
10	Door Security	2003	2,597						10
11	Generator	2003	20,145						11
12	Door Replacement	2003	1,216						12
13	Generator Replacement	2003	9,244						13
14	Elevator Repair	2003	12,378						14
15	Shower Room Remodel	2003	17,153						15
16	Hallway carpet	2003	3,889						16
17	Boiler Door	2003	854						17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,920,637	\$ 210,975		\$ 228,651	\$ 17,676	\$ 1,893,164	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,192,171	\$ 86,138	\$ 86,138	\$		\$ 991,846	71
72	Current Year Purchases	19,044						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,211,215	\$ 86,138	\$ 86,138	\$		\$ 991,846	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,761,852	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 297,113	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 314,789	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,676	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,885,010	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 19,127 Description: pager, computer equipment

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$ _____

13. /2005 \$ _____

14. /2006 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		50		50
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 50	\$	\$ 50
10	SUM OF line 9, col. 1 and 2 (e)	\$ 50			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

1		2		3		4		5		6		7		8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost									
					1	Licensed Occupational Therapist		hrs	\$		\$	257,536	\$		\$
2	Licensed Speech and Language Development Therapist		hrs				38,751				38,751	2			
3	Licensed Recreational Therapist		hrs									3			
4	Licensed Physical Therapist		hrs				397,685	3,879			401,564	4			
5	Physician Care		visits									5			
6	Dental Care		visits									6			
7	Work Related Program		hrs									7			
8	Habilitation		hrs									8			
9	Pharmacy		# of prescrpts					781,726			781,726	9			
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10			
11	Academic Education		hrs									11			
12	Exceptional Care Program											12			
13	Other (specify):						33,744				33,744	13			
14	TOTAL			\$			\$ 727,716	\$ 785,605		\$	1,513,321	14			

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 288,378	\$	1
2	Cash-Patient Deposits	17,207		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	866,806		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	40,414		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	15,971		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,228,776	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	630,000		13
14	Buildings, at Historical Cost	5,950,638		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,211,215		16
17	Accumulated Depreciation (book methods)	(2,885,010)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	1,640,341		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,547,184	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,775,960	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 215,001	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,207		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	114,707		32
33	Accrued Interest Payable	8,411		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Escrow			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 355,326	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,840,888		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,840,888	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,196,214	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,579,746	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,775,960	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,680,885	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,680,885	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,139)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(100,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (101,139)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,579,746	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,005,805	1
2	Discounts and Allowances for all Levels	(2,355,172)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,650,633	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,281,660	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,281,660	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	3,080	12
13	Barber and Beauty Care	24,405	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,069,635	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	100	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,097,220	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,044	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,044	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,031,557	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,341,024	31
32	Health Care	4,391,178	32
33	General Administration	1,765,362	33
	B. Capital Expense		
34	Ownership	518,457	34
	C. Ancillary Expense		
35	Special Cost Centers	16,675	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,032,696	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,139)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,139)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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Facility Name & ID Number Heritage Manor-Springfield

0041699

Report Period Beginning: 01/01/2003

Ending:

12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,992	2,080	\$ 54,228	\$ 26.07	1
2	Assistant Director of Nursing	1,922	2,430	49,560	20.40	2
3	Registered Nurses	27,483	28,936	623,597	21.55	3
4	Licensed Practical Nurses	48,089	51,706	826,252	15.98	4
5	Nurse Aides & Orderlies	101,557	108,331	1,211,250	11.18	5
6	Nurse Aide Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,477	1,679	15,515	9.24	8
9	Activity Director					9
10	Activity Assistants	10,361	11,092	101,123	9.12	10
11	Social Service Workers	5,607	6,302	97,307	15.44	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	36,597	39,377	342,843	8.71	15
16	Dishwashers					16
17	Maintenance Workers	16,224	17,311	165,620	9.57	17
18	Housekeepers	17,487	18,473	165,307	8.95	18
19	Laundry	10,510	11,123	105,695	9.50	19
20	Administrator	2,080	2,080	77,731	37.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,976	20,209	280,261	13.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	299,362	321,129	\$ 4,116,289 *	\$ 12.82	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 0		35
36	Medical Director	17,600		36
37	Medical Records Consultant	0		37
38	Nurse Consultant			38
39	Pharmacist Consultant	4,134		39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	825		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 22,559		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 0		50
51	Licensed Practical Nurses	0		51
52	Nurse Aides	0		52
53	TOTAL (lines 50 - 52)	\$		53

XIX. SUPPORT SCHEDULES

[illegible]

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number Heritage Manor-Springfield

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO No If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 97,791
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 8,950
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? _____
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Pellman & Dold The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. Not Complete as of this date
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

